

OWCP accepted appellant's claim for left knee derangement, cervical radiculitis and lumbar radiculitis and paid disability compensation accordingly.²

November 23, 2010 x-rays by Dr. Charles L. Cooper, a radiologist, exhibited loss of cervical and lumbar lordosis while November 29, 2010 x-rays obtained by Dr. Aspan S. Ohson, a Board-certified diagnostic radiologist, showed lumbar degenerative disc disease. December 9, 2010 magnetic resonance imaging (MRI) scans obtained by Dr. Stephen M. Hershowitz, a Board-certified diagnostic radiologist, confirmed C2-3, C5-6 and L3-4 disc bulging.

In a January 3, 2011 report, Dr. Mehran Manouel, a Board-certified orthopedic surgeon, examined appellant and observed cervical, lumbar and left knee joint-line tenderness, limited range of motion (ROM) and a positive McMurray's test. X-rays revealed left knee medial joint-line narrowing. Dr. Manouel noted that appellant previously underwent left knee surgery. He diagnosed left knee, cervical and lumbar sprains as well as cervical and lumbar disc bulging based on prior MRI scans. Dr. Manouel concluded that appellant was totally disabled due to the November 19, 2010 employment injury.

Dr. Miriam E. Kanter, a Board-certified physiatrist, related in a January 10, 2011 report that appellant was unable to return to work after the November 19, 2010 work accident. On examination, she observed cervical and lumbar paraspinal myospasms, left knee effusion, retropatellar and medial joint-line tenderness, quadriceps weakness, hypoesthesia to light touch and pinprick in the left C5-6 and L4-S1 dermatomes, limited ROM and positive McMurray, Lachman and Nachlas tests. Dr. Kanter diagnosed left knee derangement, cervical and lumbar disc displacement and possible cervical and lumbar radiculopathy. Electromyograms (EMG) and nerve conduction studies for the period January 18 to February 3, 2011 presented evidence of bilateral carpal tunnel syndrome and bilateral C6, left L5-S1 and right S1 radiculopathy. In January 17, February 1 to 7, 2011 work capacity evaluation forms, Dr. Kanter opined that appellant was totally disabled.³

A February 8, 2011 left knee MRI scan obtained by Dr. Steven W. Winter, a Board-certified diagnostic radiologist, showed medial meniscus extrusion, patellofemoral joint subluxation, femoral condyle and medial tibial plateau chondral erosion, synovitis and tricompartmental changes.

Dr. Vikas Varma, a Board-certified neurologist, advised in a March 10, 2011 report that appellant sustained an industrial injury on November 19, 2010 and was thereafter rendered totally disabled. On examination, he observed cervical and lumbar paravertebral spasms, diminished right L5-S1 dermatomal sensation to light touch and pinprick, upper and lower extremity allodynia, hyperpathia and dysesthesia, limited ROM and positive straight leg raise and cross straight leg raise maneuvers. Following a review of the radiological records, Dr. Varma diagnosed cervical and lumbar myofascial pain, degenerative disc disease and disc bulging.

² Information was incorporated into the March 22, 2011 statement of accepted facts.

³ Dr. Kanter's February 7 and March 11, 2011 reports and March 22, 2011 work capacity evaluation form incorporated the substance of his earlier records.

In an April 6, 2011 report, Dr. Laxmidhar Diwan, a Board-certified orthopedic surgeon, remarked that appellant experienced symptoms stemming from the November 19, 2010 employment injury. On examination, he observed loss of cervical lordosis, muscle spasms, paraspinal, parapatellar and joint-line tenderness, knee effusion, limited ROM and positive McMurray's test and straight leg raise maneuvers. Dr. Diwan diagnosed left knee chondromalacia, torn left medial and lateral menisci, C2-3, C5-6 and L3-4 disc bulging and muscle spasms.⁴ He recommended left knee arthroscopy, which was subsequently authorized by OWCP in April 20 and 25, 2011 letters.⁵

OWCP referred appellant for a second opinion examination to Dr. Leon Sultan, a Board-certified orthopedic surgeon. In an April 13, 2011 report, Dr. Sultan reviewed the March 22, 2011 statement of accepted facts and the medical file. On physical examination, he observed dull biceps, triceps, radial, knee jerk and ankle jerk reflexes and limited cervical, lumbar and left knee ROM. Sensory testing suggested high-glove anesthesia of the left upper extremity and high-stocking anesthesia of the right lower extremity. Dr. Sultan commented that these findings "[did] not conform to any anatomical nerve lesion or dermatome distribution" and were "highly indicative of symptom[-]magnification." He pointed out that appellant previously sustained a back injury on April 13, 2010 and underwent left knee anterior cruciate ligament repair. Dr. Sultan found that appellant was no longer disabled due to the November 19, 2010 employment injury because he did not exhibit objective signs of ongoing functional impairment and prior MRI scans supported preexisting cervical, lumbar and left knee degenerative changes. An April 13, 2011 work capacity evaluation form released appellant to regular duty.

In an April 11, 2011 report, Dr. Irfan A. Alladin, a Board-certified physiatrist, noted that appellant complained of neck and lower back pain radiating to his upper extremities and lower left extremity. On cervical examination, he observed limited ROM, muscle tenderness and positive Spurling's test, shoulder decompression, foraminal compression, Soto-Hall, axial distraction and Valsalva maneuvers. On lumbar examination, Dr. Alladin found limited ROM, C4-7 and L3-4 interspinous space tenderness, muscle spasms and positive bilateral straight leg raise, Kemp's, Patrick's, McMurray and piriformis stretch maneuvers. On left knee examination, he identified limited ROM, pes anserinus bursa pain, L4-S1 hypoesthesia to pinprick and positive valgus and varus stress tests. Dr. Alladin also elicited bilateral T1 and T12 spinous process and facet tenderness.⁶ After reviewing the December 9, 2010 and February 7, 2011 MRI scans, he diagnosed cervical radiculopathy, strain and disc bulge, lumbar radiculopathy, strain and disc bulge, low back syndrome and left knee sprain.⁷

⁴ Dr. Diwan's May 18, 2011 report essentially duplicated the content of his earlier report. His May 4, 2011 work capacity evaluation specified that appellant's left knee instability hindered his ability to squat, kneel, send, sit and stand.

⁵ The case record does not indicate whether appellant underwent this procedure following OWCP's authorization.

⁶ Dr. Alladin's notes from May 25 to June 10, 2011 reiterated similar findings.

⁷ In a June 8, 2011 report, Dr. Alladin recommended left knee arthroscopy and warned that discontinuation of medical treatment may be detrimental to appellant's recovery.

In a letter dated May 12, 2011, OWCP found that Dr. Sultan's April 13, 2011 report constituted the weight of the evidence and notified appellant of its proposal to terminate his wage-loss compensation and medical benefits on the grounds that he no longer had any disability or residuals of the work injury. It gave appellant 30 days to submit additional argument or evidence.

Counsel contended in a May 23, 2011 letter that a conflict in medical opinion existed that necessitated further development. In addition, he detailed that appellant underwent left knee surgery approximately seven years earlier and sustained injuries on November 13, 2008; January 16, 2009; and April 13, 2010 that were accepted by OWCP and designated as File Nos. xxxxxx684, xxxxxx599 and xxxxxx657, respectively. A subsequent May 24, 2011 letter asked OWCP to expand the present claim to include cervical and lumbar radiculopathy.

In an April 11, 2011 report, Dr. Mohamed K. Nour, a Board-certified orthopedic surgeon, examined appellant and observed diminished cervical, lumbar and bilateral shoulder ROM, cervical, right deltoid, right trapezius, lumbosacral and left patellar tenderness, muscle spasms, and a positive bilateral straight leg raise test. He diagnosed acute post-traumatic cervical and lumbar sprain/strain as well as left knee and right shoulder internal derangement secondary to the November 19, 2010 work accident. Dr. Nour opined that appellant was partially disabled.

By decision dated June 15, 2011, OWCP finalized the termination of wage-loss compensation and medical benefits effective June 14, 2011.

Counsel requested a video hearing, which was held on October 11, 2011. He asserted that Dr. Sultan's April 13, 2011 report relied upon an inaccurate factual and medical history. Specifically, the March 22, 2011 statement of accepted facts did not refer to appellant's previously-accepted neck and back conditions⁸ or OWCP's authorization of left knee arthroscopy.

In notes dated July 11 and August 1, 2011, Dr. Barry Katzman, a Board-certified orthopedic surgeon, found limited bilateral wrist dorsiflexion and palmar flexion and positive Tinel's sign, Phalen's test and carpal compression tests on examination. He recommended bilateral carpal tunnel release and flexor tenosynovectomy.

In an October 12, 2011 report, Dr. Diwan remarked that appellant sustained neck and back injuries on the job on November 13, 2008; January 16, 2009 and April 13, 2010. He clarified that the November 19, 2010 employment injury caused left knee chondromalacia and meniscal tearing and aggravated his preexisting cervical and lumbar conditions, resulting in radiculitis. Dr. Alladin related in an undated report that appellant's injuries in 2008, 2009 and early 2010 resolved, but he remained symptomatic as a result of the most recent November 19, 2010 work accident.⁹

⁸ Counsel cited OWCP File Nos. xxxxxx684 and xxxxxx657.

⁹ Dr. Diwan and Dr. Alladin's physical examination findings and diagnoses essentially duplicated those contained in their April 6 and 11, 2011 reports, respectively.

On December 7, 2011 OWCP's hearing representative affirmed the June 15, 2011 decision.

LEGAL PRECEDENT

Once OWCP has accepted a claim, it has the burden of justifying termination or modification of compensation benefits,¹⁰ which includes furnishing rationalized medical opinion evidence based on a proper factual and medical background.¹¹ Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing that the disability ceased or was no longer related to the employment.¹² The right to medical benefits for an accepted condition, on the other hand, is not limited to the period of entitlement to disability compensation. To terminate authorization for medical treatment, OWCP must establish that an employee no longer has residuals of an employment-related condition, which would require further medical treatment.¹³

In assessing medical evidence, the number of physicians supporting one position or another is not controlling. Instead, the weight of such evidence is determined by its reliability, its probative value, and its convincing quality. Factors that comprise the evaluation of medical evidence include the opportunity for and the thoroughness of physical examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.¹⁴

ANALYSIS

OWCP accepted that appellant sustained left knee derangement, cervical radiculitis and lumbar radiculitis as a result of a November 19, 2010 work accident. Various reports for the period January 3 to April 6, 2011 from Drs. Manouel, Kanter, Varma and Diwan placed appellant on total disability status as a result of these accepted conditions. In an April 13, 2011 report, Dr. Sultan, the second opinion examiner, disagreed and concluded that appellant was no longer disabled due to the November 19, 2010 employment injury and no longer had residuals of that injury. Subsequent medical records for the period April 11 to October 12, 2011 from Drs. Alladin and Diwan reiterated that he remained on total disability while a separate April 11, 2011 report from Dr. Nour supported partial disability. OWCP determined that Dr. Sultan's opinion constituted the weight of the evidence and thereafter terminated appellant's entitlement to disability compensation.

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits.

¹⁰ *I.J.*, 59 ECAB 408 (2008); *Fermin G. Olascoaga*, 13 ECAB 102, 104 (1961).

¹¹ *D.C.*, Docket No. 09-1070 (issued November 12, 2009); *Larry Warner*, 43 ECAB 1027 (1992).

¹² *I.J.*, *supra* note 10.

¹³ *L.G.*, Docket No. 09-1692 (issued August 11, 2010); *Furman G. Peake*, 41 ECAB 361, 364 (1990).

¹⁴ *Anna M. Delaney*, 53 ECAB 384, 386 (2002).

To assure that the report of a medical specialist is based upon a proper factual background, OWCP provides information through the preparation of statement of accepted facts.¹⁵ The statement of accepted facts is the means by which factual findings are separated from medical findings and opinions. Clear factual findings are aimed at preventing physicians from making erroneous factual assumptions about the case, which could undermine their medical conclusions.¹⁶ When an OWCP medical adviser, a second opinion specialist, or a referee physician renders a medical opinion based on a statement of accepted facts which is incomplete or inaccurate, the probative value of the opinion is seriously diminished or negated altogether.¹⁷ In this case, Dr. Sultan's conclusion that appellant had preexisting cervical and lumbar degeneration was based on a deficient March 22, 2011 statement of accepted facts, which did not include information about appellant's previously-accepted neck and back conditions in 2008 and early 2010. OWCP procedures require case doubling when a new injury is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body.¹⁸ Because Dr. Sultan's knowledge of the facts and medical history was incomplete, his opinion was undermined. The reports from Drs. Manouel, Kanter, Varma, Diwan and Alladin presented thorough physical examination findings and consistent analyses, supported total disability causally related to appellant's federal employment. Therefore, the Board finds that OWCP improperly determined that Dr. Sultan's report constituted the weight of the evidence.

CONCLUSION

The Board finds that OWCP improperly terminated appellant's wage-loss compensation and medical benefits effective June 14, 2011.

¹⁵ *Mirna Cruz*, Docket No. 06-183 (issued April 5, 2006).

¹⁶ FECA (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.809.2(c) (September 2009).

¹⁷ *A.R.*, Docket No. 11-692 (issued November 18, 2011); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990). *See also M.W.*, 57 ECAB 710 (2006); *James A. Wyrick*, 31 ECAB 1805 (1980) (medical opinions based on an incomplete or inaccurate history are of diminished probative value).

¹⁸ FECA (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance & Management*, Chapter 2.400.8(c) (February 2000).

ORDER

IT IS HEREBY ORDERED THAT the December 7, 2011 decision of the Office of Workers' Compensation Programs is reversed.

Issued: November 6, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board